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No. 88-1503

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

NANCY BETH CRUZAN, by her parents and co-guardians, LESTER L. and JOYCE CRUZAN,
Petitioners,

v.

ROBERT HARMON, Director of the Mississippi Department of Health, and DONALD LAMKINS, Administrator of the Missouri Rehabilitation at Mount Vernon,
Respondents,

v.

THAD C. MCCANSE,
Guardian Ad Litem,
Respondent.

On Petition for a Writ of Certiorari to the Supreme Court of Missouri

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BRIEF AMICUS CURIAE OF THE NATIONAL ACADEMY OF ELDER LAW ATTORNEYS IN SUPPORT OF PETITIONERS

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BRIEF AMICUS CURIAE OF THE NATIONAL ACADEMY OF ELDER LAW ATTORNEYS IN SUPPORT OF PETITIONERS

INTRODUCTION: WHY THE NATIONAL ACADEMY OF ELDER LAW ATTORNEYS IS INTERESTED IN THE CASE AT BAR.

This friend of the court brief is filed on behalf of the National Academy of Elder Law Attorneys (NAELA).[1] NAELA now has approximately 400 member attorneys

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[1] All parties have consented to the filing of this brief. Such consents have been filed with this Court.

who practice in the emerging area of "elder law." Elder law practitioners place as much emphasis on health care decision-making issues encompassing those now before the Court as they do on traditional estate planning considerations. See Gilfix and Strauss, *New Age Estate Planning: The Emergence of Elder Law*, Trusts & Estates, (April 1988).

Central to the NAELA mission is the provision of information, education, and assistance to attorneys, bar organizations, and others who advise elders and their families. As importantly, membership criteria require that attorneys who render legal services for the benefit of elderly people have an understanding of the aging process and a sensitivity to their needs. Members must be committed to the highest standards of ethics in representing the needs of and promoting the welfare of older people.

As such, elder law attorneys are frequently involved with clients and families who are facing life and death decisions, both in the planning context and in situations requiring practical and immediate decisions where the life and future of a loved one hangs in the balance. Our members have represented families facing issues conceptually identical to those involved in the case at bar. The authors of this *amicus* brief, for example, were prevailing attorneys in California's leading authority, *In re Drabick*, 200 Cal.App.3d 185, 245 Cal.Rptr. 840 (Cal. Ct. App. 1988), *review denied* (Cal. July 28, 1988), *cert. denied*, 109 S.Ct. 399 (1988).

Our members daily serve people—both young and old—who demand that their wishes about the use or non-use of life-sustaining treatment be respected if they should ever be in a medical condition like that of Nancy Beth Cruzan. Our members have also been called upon to serve people with loved ones in her condition or who are otherwise permanently incapacitated.

NAELA believes that the issues presented to the Court are of paramount and overwhelming importance to its constituency and to the thousands of families served by its membership each year. NAELA believes that if the opinion of the Supreme Court of the State of Missouri is upheld, and if the standards set forth in that opinion are accepted by this Court, the rights of elders, their families, and all medical care patients in the nation will be severely undermined and grievously eroded.

SUMMARY OF ARGUMENT

The *Cruzan* court improperly elevated the state's interest in preserving life, regardless of circumstances, to an absolute. It improperly denigrated the right of an individual or a surrogate to refuse unwanted, futile medical treatment. In so doing, it ignored precedent, violated constitutional principles, and developed an invasive, mechanical approach to a uniquely human problem.

The *Cruzan* court failed to appreciate the potentially harmful impact of medical technology. More importantly, it failed to appreciate and gave no weight to the concept of human dignity, which is at the very core of these deliberations. The implications of compelled treatment are massive and assaultive on many levels.

The *Cruzan* court concluded that no unacceptable burden was imposed on Nancy Cruzan by the gastrostomy. Findings of fact and application of the analytic approach urged by amicus clearly indicate the presence of burden.

Court involvement in decisions regarding the use or non-use of life-sustaining treatment is typically inappropriate and unnecessary. Where a legally reliable writing exists, the expressed wishes of the patient must be respected without court review. In other cases, as here, family members are the most appropriate surrogates; they should rely on their good faith understanding of what their loved one would want or, where they have no basis for making this determination, what is in their loved one's best interest. Court review is appropriate

where there is disagreement or allegation of an improper motivation.

Adoption of the benefit vs. burden, proportionate treatment test is appropriate. This approach focuses on benefits to be gained from a particular treatment and defines benefits in terms of recovery or return to an aware, sentient existence.

Given all of the foregoing, reversal and adoption of the standard proffered by amicus NAELA are imperative.

ARGUMENT

I. THE STATE'S INTEREST IN PRESERVING THE LIFE OF A PERSON IN A PERSISTENT VEGETATIVE STATE IS NOT PARAMOUNT TO THE RIGHTS OF THE INDIVIDUAL.

Virtually unprecedented is the statement that "[T]he state's interest is not in quality of life. . . . Were quality of life at issue, persons with all manner of handicaps might find this state seeking to terminate their lives. Instead, the state's interest is in life; that interest is *unqualified.*" (Emphasis added) Appendix to the Petition For a Writ of Certiorari (Pet. App.) 29

With that radical and sweeping statement, the *Cruzan* court departed from the overwhelming weight of authority. In our judgment, it also launched a palpable assault on the constitutional and human rights of all medical care patients and their families in this country. Indeed, if the *Cruzan* court has its way, state government will no longer be a protector of individual rights, as it has been in the twenty-two (22) jurisdictions which allowed or allow withdrawal of life-sustaining treatment in appropriate circumstances.[2] See, *e.g., In re Drabick, supra*; *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417,

[2] A complete listing may be found on pages 4 and 5 of the Amicus Curiae Brief of the Society for the Right to Rie, Inc. in support of the Petitioners.

497 N.E.2d 626 (1986); *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987).

Rather, state government will become the arbitrary force about which our constituency is concerned: a force which can mandate unwanted, invasive, humiliating, costly, and, in the opinion of the vast majority of Americans, pointless care. The implications of this position are immense.

This Court ought not be guided by the vagaries of public opinion. The attitude of the American population about the use of life-sustaining treatment in some circumstances is relevant, however, when it is so strong and consistent that it approaches the status of a national ethic.

A 1987 poll conducted by the Field Institute of California revealed, for example, that 81% of Californians interviewed agreed that the next of kin should be empowered to have an incurably ill patient's life-support systems turned off. McLeod, *'Right to Die' Wins Widespread Favor*, San Francisco Chronicle, June 8, 1987. In an American Medical Association poll of 1,510 persons, 73% approved "withdrawing life-support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their families request it." *Society for the Right to Die Newsletter*, Spring, 1987. Gallup (Jan. 1985) and Harris (Jan. 1985) surveys revealed 81% and 85% concurrence, respectively, with similar statements. *Society for the Right to Die Newsletter*, Spring, 1985.

Admittedly anecdotal, NAELA members consistently report passionate statements from older clients, in particular, expressing fear about unwanted treatment. As recently stated to the authors by an 82 year old nursing home patient, "They ain't going to stick no tubes in me!"

Consider the reaction of this gentleman if we must tell him that tubes may indeed be "stuck" in him and remain there indefinitely if the principal *Cruzan* opinion has its way.

Technology which allows for tube feeding is a blessing when it maintains life while cure or improvement for the underlying condition of the patient is sought. It becomes a curse—an end in itself—when it is unremittingly employed even after all reasonable attempts have been made to effect recovery. Medical technology ceases to be a tool available for the enhancement of life; it serves only to prolong organic life. Rather than decisions made by human beings who have the patient's best interests at heart, the existence of the technology itself makes the decision. The backlash of such analysis as employed by the *Cruzan* principal decision is important to contemplate. Will elders and others increasingly fear to enter the quagmire of high technology to seek needed help because of the fear that they, too, may become victim to endless and unwanted life-sustaining treatment? Will families waiting in hospital emergency rooms be forced to choose irrevocably to begin life-sustaining treatments, knowing that once initiated, no court will permit removal of life-sustaining measures, even after all hope is gone?

We believe that the *Cruzan* approach and the fears that it would engender would ironically *result in needless deaths* where recovery may, in fact, be possible. We believe that many elders would refuse hospitalization and life-*saving* treatment because of overriding worries about unwanted life-*sustaining* treatment.

The notion that a medical procedure must be used simply because it exists and can maintain life is before us. The *Cruzan* Court would, in effect, computerize medical care and objectify it to the point where the patient has no choice and the physician becomes a mere technician.

Moreover, courts have acknowledged limitations on the absolute preservation of life. The First Amendment of

the United States Constitution guarantees freedom of religion, even where the practice of that religion results in individual decisions to forego life-sustaining treatment. *In re Estate of Brooks*, 32 Ill.2d 361, 205 N.E.2d 435 (1965). In other fact situations, competent patients are allowed to reject potentially life-saving or life-sustaining treatment for reasons that need neither be explained nor justified to the physician. *See Bouvia v. Superior Court*, 179 Cal.App.3d 1127, 225 Cal.Rptr. 297 (Cal. Ct. App. 1986); *Bartling v. Superior Court*, 163 Cal.App.3d 186, 209 Cal.Rptr. 220 (1984); *Cf. Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678 (1965).

Missouri is a state in which there is capital punishment. *See* dissenting opinion of Blackmar, J., Pet. App. 49. As pointed out by Judge Blackmar, Missouri law (and the laws of most states in this nation) also allows for "living wills" that constitute the "planned termination of life." He also points out a conceptual flaw in the majority's everything-for-everybody mandate.

> The absolutist provision is also infirm because the state does not stand prepared to finance the preservation of life, without regard to the cost in very many cases. . . . Many people die because of the unavailability of heroic medical treatment. It simply cannot be said that the state's interest in preserving and prolonging life is absolute.

Pet. App. 49. Indeed, many elderly clients cite concern about the cost of ongoing care and resulting economic harm to a surviving spouse or other family member. The Missouri Supreme Court majority would somehow place itself above this worry.

We submit that the majority developed an absolutist position that has no basis in legal precedent or logic. Perhaps best said by the court in *In re Drabick*:

> [T]o speak of the state's interest in preserving life is really to miss the point. To put it more precisely,

> the state has an interest in protecting [the patient's] right to have appropriate medical treatment decisions made on his behalf. The problem is not to preserve life under all circumstances but to make the right decisions. A conclusive presumption in favor of continuing treatment impermissibly burdens a person's right to make the other choice.

In re Drabick, supra, 200 Cal.App.3d 185, at 209.

II. BY IGNORING THE CONCEPT OF HUMAN DIGNITY, THE MAJORITY FAILS TO UNDERSTAND THE CONCEPT OF "BURDEN."

While by no means accepting the "burdens vs. benefits" analysis utilized by so many courts in this nation, the majority did allow that treatment may be discontinued where an unacceptable level of pain cannot otherwise be avoided. Because Ms. Cruzan is reportedly not in severe, apparent pain, the majority holds that she is not "burdened" by the gastrostomy tube that has been surgically inserted into her stomach. Pet. App. 38

One wonders, did a member of the majority ever *see* an implanted gastrostomy tube? The gastrostomy is only one of a number of burdens suffered by unconscious patients. Patients in a persistent vegetative state do not rest peacefully. The medical problems associated with this condition are discussed in Whyte and Glenn, *The Care and Rehabilitation of the Patient in a Persistent Vegetative State*, Head Trauma Journal, Vol. 1, No. 1 page 39 (April 1986). The authors outlined an approach which was designed, in part, to "prevent iatrogenous causes of impairment, and promote the comfort of the patient *and the family*" (emphasis supplied). The authors suggest clinical methods to manage seizures, hypertension, hydrocephalus, aspiration pneumonia, urinary tract infections, decubitus ulcers, disorders of muscle tone (including contractures), heterotopic ossification and bowel and bladder management. The prevention of decu-

bitus ulcers (bed sores) and the management of bowel and bladder incontinence impact the care, dignity and personhood of a totally non-responsive patient. "Fecal incontinence discourages staff and family interaction, terminates therapy sessions and predisposes to skin breakdown and urinary tract contamination." Urinary incontinence can be managed, but for female patients (such as Nancy Cruzan) physicians "must choose between indwelling catheters and adult diapers and balance the risks of "urinary tract infection" against the potential for "skin breakdown" in females who may suffer from a common consequence of brain injury "which results in such frequent voiding that the patient is virtually never dry." *Whyte, supra*, at 50.

Judge Blackmar in his dissenting opinion emphasized the *Brophy* court's conclusion that "the maintenance of Paul Brophy, . . . [Bathing, shaving, mouthcare, grooming, caring for bowels and bladder, changing his bed linens and clothing, turning him in bed, and providing him with food and hydration through the G-Tube] for a period of several years is intrusive treatment as a matter of law." Pet. App. 36. His own direct response: "I simply fail to understand the statement in the principal opinion that this procedure [the gastrostomy] is not heroically 'invasive'." (Footnote 2) Pet. App. 46.

The Missouri Supreme Court's analysis ignores our humanity. It does not acknowledge, let alone value, the emotional reaction to such treatment. It fails to do this even though court after court has described feelings of "humiliation," "mortification," "indignity," and assaults on an individual's humanity. (*See, inter alia, In re Drabick, supra*, 200 Cal.App.3d 185 at 195-6, 207, 245 Cal.Rptr. 840 at 854-855, *In re Torres*, 357 N.W.2d 332 at 340 (Minn., 1984), *Bouvia v. Superior Court*, 225 Cal.Rptr. 297, at 305 (Cal. Ct. App. 1986); the separate opinion

of Judge Handler in *In re Conroy*, 98 N.J. 321 at 398-9, 486 A.2d 1209; *Brophy v. New England Sinai Hospital*, 398 Mass. 417, 497 N.E.2d 626, at 636 (1986).

The closing words of Judge Blackmar, dissenting, Pet. App. 51, could not be more poignant:

> The principal opinion attempts to establish absolutes, but does so at the expense of human factors. In so doing it unnecessarily subjects Nancy and those close to her to continuous torture which no family should be forced to endure. I am grasping for words which elude me, and so will not say more.

Judge Blackmar's difficulty, his grasping for words, and his obvious frustration illustrate the dilemma that this Court faces and that the majority utterly failed to consider. It is the fact that judges, trained in the law, can suffer from an analytic blind spot. They can forget that real people with intense feelings, worries, and fears are profoundly affected by their decisions. Judge Blackmar implicitly recognizes this by his reliance on "human factors".

The point is that the somewhat ephemeral concept of human dignity is at the very core of these deliberations. An assault on dignity is as palpable as an assault on one's body.

It is also an indirect assault on a patient's family, as Judge Blackmar noted. The majority dismisses family feelings, convictions and motivations by disparagingly referring to the "inconvenience" that continuing life-sustaining treatment "might cause others". Pet. App. 26. Rather than summarily dismissing family motives as selfish and self-serving, we believe that they must instead be valued and respected. Indeed, family members should be intimately involved in the decision-making process where the patient herself has not made her wishes known

in written or other reliable manner. The Court in *McConnell v. Beverly Enterprises* 209 Conn. 692, 553 A.2d 596 (1989) held that when "a family is unanimous . . . the court must place great weight on their decision to enforce the desires of their loved one." The decision in *Drabick* recognized the feelings, convictions and motivations of the Conservatee's family and loved ones, saying:

> Whether the benefits of treatment outweigh its detriments is a decision that engages personal and medical values, including ideas about the quality of life. It is not a decision that courts are constituted or especially well qualified to make.
>
> Above all, these decisions are for the persons affected by them. *In re Drabick, supra*, at 196.

The *Drabick* court considered carefully the testimony of Mr. Drabick's family and loved ones.

If the principal *Cruzan* opinion stands, Missouri families would be forbidden to carry out the final wishes of their loved ones. In some cases, they would be forbidden to carry out a last promise made to a spouse, parent, or child. That court, by its absolutist approach, intrudes not only on the patient's privacy, and on the patient's right to have appropriate medical decisions made on her behalf, but also on the most intimate relationships of family members.

III. THE MAJORITY IGNORED FINDINGS OF FACT; BY ITS OWN TERMS, "BURDEN" EXISTS.

While the majority apparently does not agree, a physical assault is in progress. Indeed, many of us have personally witnessed the apparent discomfort caused by a feeding tube. We have read medical records (of patients in persistent vegetative state) indicating treatment goals that amount to nothing more hopeful than to attempt to avoid bedsores, diarrhea, and contractures for the help-

less patient. Such were and are the goals for Nancy Beth Cruzan.

Three neurologists, a neurosurgecn and a number of physicians concluded that "she has no cognitive or reflexive ability to swallow food or water to maintain her daily essential needs [and] [t]hat she will never recover her ability to swallow sufficient[ly] to satisfy her needs." Pet. App. 95. She remains unconscious, [and due to the contractures] her fingernails now sometimes cut into her wrists. A CAT scan indicated abnormalities had developed in her brain which suggest that her brain had degenerated since her initial injuries. Pet. App. 56.

Nancy Beth Cruzan presumably feels no pain in the ordinary course of her day. She is diagnosed as being in a persistent vegetative state. (See Gilfix, Gilfix, and Sinatra, *Law and Medicine: The Persistent Vegetative State*, Head Trauma Journal, Vol. 1, No. 1 at 63-71 (April 1986)). Significantly, in fact, the trial court found by clear and convincing evidence the following fact: "That she is oblivious to her environment except for reflexive responses to sound and *perhaps to painful stimuli.*" It also found "that her highest cognitive brain function is exhibited by her grimacing perhaps in recognition of ordinarily painful stimuli, indicating the experience of pain. . . ." Further, "she has contractures of her four extremities which are slowly progressive with irreversible muscular and tendon damage to all extremities." Pet. App. 95.

Even relying on its own, albeit improper, definition of burdens imposed on this patient, a different outcome is mandated. More importantly, her existence without sentient awareness forces her into a position of accepting nutrition without appetite. Her treatment goals speak of avoiding more injury, rather than to achieve recovery or even to improve her life.

This burden of accepting nutrition is recognized by the holding reached in *In re Gardner*, 534 A.2d 947, 955 (Me. 1987), where the court stated "There is no symbolic virtue in imposing [a feeding tube] upon the body of a person who previously declared that he would not want to receive such treatment but who now is no longer able personally to prevent what is being done to his body." Again, the protective role of family members inevitably emerges as it did for Nancy Beth Cruzan.

IV. COURT INVOLVEMENT IS NOT NECESSARY.

Dissenting Judge Blackmar states succinctly "that no state policy requires the state to intervene in these decisions." Pet. App. 47. As he points out, historically, medical decisions have been made by the patient if able, and if not, by those closest to the patient. "This is nothing new in substituted decision making. The state is seldom called upon to be the decision maker." Pet. App. 47.

Decisions such as are involved in Nancy Cruzan's care are "made daily by the patient or loved ones on the basis of medical advice and their conclusion as to what is best." Where the patient is unable to speak for herself and has left nothing in writing to indicate her preferences, it is common sense that "[t]hose closest to the patient are best positioned to make judgments about the patient's best interest." Pet. App. 48.

The impact on local judicial systems will be staggering if routine court involvement is mandated in every instance where families, like the Cruzans, face this most wrenching decision. Limited societal and family resources and sorely taxed emotional energy will be used not to bring comfort to patients and implement their preferences, but to litigate their final wishes.

The President's Commission for the Study of Ethical Problems in Medicine and Bio-medical and Behavioral Research considered this issue in a report entitled *Decid-*

ing to Forego Life Sustaining Treatment: Report on the Ethical, Medical, and Legal Issues in Treatment Decisions (1983) [Hereinafter "Report of the President's Commission".] This report estimated that at any one time there were approximately 5,000 permanently unconscious patients in the United States. If anything, the numbers are even greater today: decisions to maintain or withdraw life-sustaining treatment are being made every day in every state in the nation. Testimony to this Commission indicated that in Pittsburgh, Pennsylvania, at one university hospital alone, between 500 and 1000 patients had life-sustaining treatment withdrawn because of permanent brain damage.

The Minnesota Supreme Court in *In re Torres* reported that "on an average about 10 life support systems are disconnected weekly in Minnesota". *In re Torres, supra,* 357 N.W.2d 332, 341 fn. 4 (1984).

If hearings are routinely to occur, each court would necessarily conduct a psychological examination of the silent patient's intent and/or hear a protracted debate about the quality of life for this patient or quality of life issues in general. Different jurisdictions will develop different standards; appeals will wear down family members. Medical care providers will be unable to respond to their patients' desires or to assist families in their most critical moments of need.

Unfortunately, neither the courts nor the State will be in any better position to make these decisions than family members. In the opinion of both Judge Blackmar (see dissenting opinion Pet. App. 47) and the court in *In re Drabick, supra,* 200 Cal.App.3d 185, 196 (1988), neither the state nor the courts should try.

We urge the position of the unanimous court in *In re Drabick, supra,* which in essence, held that the patient's loved ones may ordinarily make important decisions of this kind without going to court, so long as they are made

in good faith and unless there is a challenge. That court relied substantially on an earlier California case, *Barber v. Superior Court of Los Angeles,* 147 Cal.App.3d 1006, 1021, 195 Cal. Rptr. 484 (Cal. Ct. App. 1988) in which the court stated that "in the absence of legislative guidance, we find no legal requirement that prior judicial approval is necessary before any decision to withdraw treatment can be made." The *Drabick* court indicated that "judicial involvement is necessary in a decision to forego medical treatment for a persistently vegetative patient only if the interested parties disagree." *In re Drabick, supra,* at 194.

In accord was the court in *In re Farrell,* in which the New Jersey Supreme Court expressed its concern about mandated recourse to the courts.

> No matter how expedited, judicial intervention in this complex and sensitive area may take too long. Thus, it could infringe the very rights that we want to protect. The mere prospect of a cumbersome, intrusive and expensive court proceeding, during such an emotional and upsetting period in the lives of the patient and his or her loved ones, would undoubtedly deter many persons from deciding to discontinue treatment. And even if the patient or the family were willing to submit to such a proceeding, it is likely that the patient's rights would nevertheless be frustrated by judicial deliberation. Too many patients have died before their right to reject treatment was vindicated in court. *See, e.g., Conroy, supra,* 98 *N.J.* at 342, 486 *A.*2d 1209; *Bartling, supra,* 163 *Cal.App.*3d at 189. 209 *Cal.Rptr.* at 221; *John F. Kennedy Memorial Hosp. v. Bludworth,* 452 *So.*2d 921, 923 (Fla.1984); *Satz v. Perlmutter, supra,* 379 *So.*2d 359; *Corbett v. D'Alessandro,* 478 *So.*2d 368, 369 (Fla.Dist.Ct.App.), review denied, 492 *So.*2d 1331 (Fla.1986); *In re L.H.R.,* 253 *Ga.* 439, 321 *S.E.*2d 716 (1984); *In re Spring,* 380 *Mass.* 629, 631 n. 1, 405 *N.E.*2d 115, 118 n. 1 (1980); *Sackiewicz, supra,* 373 *Mass.* at 734, 370 *N.E.*2d at 422; *In re Storar,* 52 *N.Y.*2d 363, 369 n. 1, 420 *N.E.*2d 64, 66 n. 1, 438

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In re Farrell, 108 N.J. 335, 529 A.2d 404, at 415 (N.J. 1987).

As expressed by Judge Blackmar and embodied in many thoughtful opinions, medical care decisions like those involved here ought not be routinely made by courts unless there is a challenge or other compelling reason exists. Good faith decisions made by intimates who take into account the values and preferences of the loved patient, as well as the advice and prognosis of medical professionals, will achieve humane results that respect the rights of the patient.

Presuming evil motives and base purposes with a concurrent requirement to prove the absence of such motives and purposes in every case can achieve little that is constructive. A role must be preserved for family and good faith; required resort to the courts will foster frustration and cynicism at the expense of commitment from family members who are already facing enormous stress and grief.

Those of us who represent elderly clients frequently see family members trying to cope with circumstances in which loved ones are already incapacitated, and who have left behind no written directives. Most of these people know—both rationally and instinctively—what their loved one would want. They know either because they discussed the issue, perhaps in deep philosophical discussion or perhaps in brief, but memorable, conversation. Or, they know because they are intimately acquainted with the personal values and approach to life of their loved one before she or he lost capacity. As recognized by the *Jobes* court: "Generally it is the patient's family or other loved ones who support and care for the patient, and who best understand the patient's personal values and beliefs. Hence they will be best able to make a substituted medical judgment for the patient." *In re Jobes*,

108 N.J. 394, 529 A.2d 434, at 451 (N.J. 1987). (See also Newman, *Treatment Refusals for the Critically Ill: Proposed Rules for the Family, the Physician, and the State*, III N.Y.L.J. HUMAN RIGHTS ANNUAL 45-46 (1985)).

For all of these reasons, family members are typically the persons in the best position to evaluate the medical information available. They are in the best position to decide whether to refuse or to continue to accept life prolonging treatment on behalf of their silent loved one.

Because we urge reliance on its analytic approach and outcome, some discussion of factual circumstances in California's leading case, *In re Drabick*, *supra*, is helpful.

William Drabick, like Nancy Cruzan was rendered irrevocably unconscious for several years. The *Drabick* opinion, *supra*, at 190, described his situation as follows:

> William is now in a nursing home. In the five years since the accident he has remained unconscious in a persistent vegetative state, or coma. Because his electroencephalogram is not flat he is not "brain dead." Moreover, he breathes without the assistance of a respirator. For these two reasons, California law considers him to be alive. However, he is unconscious, his eyes remain closed, and he is not capable of voluntary movement. He does not communicate or respond to sound or physical stimulation. He does not usually respond to painful stimuli. When he does respond it is only with a nonspecific tremor. William is totally unable to care for himself or to sustain his own life. He cannot eat but is given nourishment and water through a nasogastric tube. (footnotes omitted)

The California Sixth Appellate District Court reversed the Superior Court to allow William's brother to decide the course of his medical treatment; in this instance, to decide to remove the nasogastric feeding tube.

> We are convinced that we deprive William of a fundamental right if we uphold the superior court's decision. At present William's treatment is deter-

> mined solely as a matter of medical technology; his life is prolonged because it is possible, not because anyone purporting to speak for him has decided that this is the best or the wisest course. Under California law, however, human beings are not the passive subjects of medical technology.

In re Drabick, supra, at 208.

The Appellate Court explicitly acknowledged the right of the family to consider medical advice and the incompetent person's best interests. It found that both California law and constitutional law give each of us a fundamental right to determine the scope of our own medical treatment: "[T]his right survives incompetence in the sense that incompetent patients retain the right to have appropriate decisions made on their behalf, [. . .] The state's interest in preserving life does not outweigh the patient's own rights." *In re Drabick, supra,* at 205.

William Drabick's comatose condition did not make it possible for him to participate in decisions. Similarly, Nancy Cruzan's persistent vegetative state precludes her participation. It is possible for others—in this case, her parents—to make a decision that reflects her interests more accurately than a purely technological decision to do whatever is possible. Nancy Cruzan has a right to a decision that takes her interests into account.

William Drabick's prior statements were important to the Court, but not determinative. *In re Drabick, supra,* 200 Cal.App.3d 185, at 210. They were to be taken into account as part of his known preferences in determining his own individual best interest, but they did not need to be "clear and convincing evidence" nor did they amount to his own exercise of his right to refuse treatment. *Id.* at 211.

The California Appellate Court confirmed that families and physicians may together decide, without court involvement, whether to continue to forego life sustaining treatment.

> [F]aced with a persistently vegetative patient and a diagnosis establishing that further treatment offers no reasonable hope of returning the patient to cognitive life, the decision whether to continue noncurative treatment is an ethical one for the physicians and family members or other persons who are making health care decisions for the patient.

In re Drabick, supra, at 204.

V. WE URGE ADOPTION OF THE "BENEFIT VS. BURDEN", PROPORTIONATE TREATMENT STANDARD.

In 1983, the Report of the President's Commission urged adoption of the "proportionate treatment test" in situations where an individual did not make his wishes known in a legally acceptable writing or by some other reliable means. We urge adoption of this approach by the Court.

This analysis focuses on "whether the benefits of the treatment outweigh the detriments." *In re Drabick, supra,* at 196. Relying on the earlier California case, *Barber v. Superior Court, supra,* 147 Cal.App.3d 1006. The *Drabick* court explained this concept:

> "[P]roportionate treatment is that which, in the view of the patient, has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment. Thus, even if a proposed course of treatment might be extremely painful or intrusive, it would still be proportionate treatment if the prognosis was for complete cure or significant improvement in the patient's condition. On the other hand, a treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in condition." [*Id.* at 1019)

In utilizing this approach, the surrogate decision maker (be it a formally appointed conservator or a fam-

ily member, neither of whom would require court approval before making treatment decisions) should be guided by the patient's "best interests." Such review includes the consideration of "such factors as relief of suffering, the preservation or restoration of functioning and the quality as well as the extent of life sustained." *Barber, supra*, 147 Cal.App.3d at 1021, citing the Report of the President's Commission, *supra*, at 134-135. Also, "[s]ince most people are concerned about well-being of their loved ones, . . . the surrogate may take into account the impact of the decision on those people closest to the patient." *Id.* at 1021. See also *In re Torres*, 357 N.W.2d 332, at 338-339 (Minn. 1984), citing a lengthy discussion of patient interests in the Report of the President's Commission, *supra*, at 181-183.

The *Barber* court also found "something of a consensus" on the standard to be applied when dealing with patients for whom the possibility of full recovery is remote or virtually non-existent, and who are incapable of expressing their views. *Barber, supra*, 147 Cal.App. 3d at 1019.

For example, the court in *Quinlan* said, "The focal point of the decision should be the prognosis as to the reasonable possibility of sapient life, as distinguished from the forced continuance of that biological, vegetative existence. . . ." *In re Quinlan, supra*, 355 A.2d at 669. *See also In re Dinnerstein*, 380 N.E.2d 134, 138 (Mass. App. 1978), *overruled on other grounds*, 399 N.E.2d 493, 405 N.E.2d 115 (1980), where the court stated, " 'prolongation of life', does not mean a mere suspension of the act of dying, but contemplates, at the very least, a remission of symptoms enabling a return towards a normal, functioning, integrated existence." *Id.* at 138.

As noted and discussed above (Section B herein), a question apparently exists as to whether the gastrostomy is intrusive and burdensome for Nancy Cruzan.

Commenting on intrusions and, implicitly, the concept of "benefits vs. burden," Judge Handler in New Jersey's *In re Conroy, supra*, 98 N.J. 321, 398-9, stated, "eventually, pervasive bodily intrusions, even for the best motives, will arouse feelings akin to humiliation and mortification for the helpless patient." The Massachusetts Supreme Judicial Court observed in *Brophy*:

> In certain, thankfully rare circumstances, the burden of maintaining the corporeal existence degrades the very humanity it was meant to serve. The law recognizes the individual's right to preserve his humanity, even if to preserve his humanity to allow the natural processes of a disease or affliction to bring about a death with dignity.

Brophy v. New England Sinai Hospital, Inc., 497 N.E.2d 626, at 635 (Mass. 1986).

The "benefits versus burdens" approach has been adopted by medical associations and state agencies. Ruark, Raffin, and The Stanford University Medical Center Committee on Ethics, *Initiating and Withdrawing Life Support*, 318 New England J. Med. 25 (1988), which specifically adopts the proportionate treatment analysis, urges its use in medical care settings, and states that conservatorship proceedings are not routinely necessary. This article and other policy statements indicate the acceptance and workability of this approach in the medical community. (See also the position of the Council on Ethical and Judicial Affairs of the American Medical Association, *Withholding or Withdrawing Life-Prolonging Medical Treatment* (March 1986).)

Here, two factors indicate why application of this standard would result in affirmation of the trial court's findings. First, the medical procedure utilized is inherently and substantially intrusive. Second, the treatment offers no hope for improvement or recovery. There is a compelling, ongoing "burden" and there is no concomitant "benefit".

The state exists to serve and protect the rights of the individual. The state has an interest in defending the right of the patient to make [her] own medical care decisions. *In re Drabick*, *supra*, at 206.

Adoption of this standard will establish a consistent, workable approach that is respectful of patient rights. Application of this standard compels reversal.

CONCLUSION

America's elderly citizens—more accurately, all citizens—have a direct and palpable interest in the case at bar. In jeopardy is the right of the individual to determine the course of medical treatment to which his body will be subjected, or to have family members make that determination for the individual. At issue is the very concept of the right to privacy, the right to refuse bodily invasions against one's will.

Indeed, *Cruzan* provides a remarkable opportunity for the United States Supreme Court to meaningfully protect the rights of its citizenry. If this is not done, and if the *Cruzan* position is affirmed, the worst fears of the elderly population will have been realized.

We urge the Court to reverse the opinion of the majority and to adopt the principles set forth herein.

Respectfully submitted,

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